

Austin Chiropractic Center, Inc.
 Paul D. Austin, DC, CCSP, DACNB
 262 S. McCaslin Blvd, Louisville, CO 80027
 303-665-5405

TIME OF SERVICE PLAN (TOS) PAYMENT PLAN

DEFINITION:

Under this payment method, charges for services are paid in full immediately after they are delivered, and no paper work is performed, other than a receipt.

METHOD OF PAYMENT:

We accept cash, check, credit card, money orders or traveler's check. The check must be negotiable at the time of payment.

BOUNCED CHECKS:

For checks that fail to clear the bank, or any other type of payment that proves non-negotiable, not only will the necessary paperwork plan fee schedule apply, but there will also be returned check and handling charges.

ADMINISTRATIVE SERVICES THAT ARE NOT COVERED:

Since a reduced fee is charged for services, no documents will be supplied to the patient for reimbursement by a third party, including copies of medical records, diagnosis, completion of forms or questionnaires, writing of report, preparation of insurance bills, etc. However, a receipt will be given at the time of payment.

IF ADMINISTRATIVE SERVICES ARE REQUESTED:

If any of the previously mentioned documents are requested subsequent to payment of the reduced fee, the difference between the reduced charge and the billed charge will be paid by the patient (on all related services) prior to the preparation of the documents.

THIS PLAN IS SET BY THE CLINIC AND IS ONLY IN EFFECT AS LONG AS YOU ARE KEEPING THE SCHEDULE THE DOCTOR HAS SET FOR YOUR CARE. IF YOU REPEATEDLY MISS APPOINTMENTS AND DO NOT ADHERE TO THE SCHEDULE THE DOCTOR HAS SET FOR YOU, YOU WILL NOT BE ELIGIBLE FOR THIS PLAN.

Insurance Fee Schedule Varies with Contract Rates

Initial exam	\$150.00-190.00
Spinal adjustment	\$ 60.00-80.00
Therapies	\$30.00-60.00

(Therapies include Myofascial Release, Intersegmental Traction, Therapeutic Exercises, Cold Laser, Neuromuscular Re-education, etc.)

Time of Service/Non-Ins. Fee Schedule

Initial exam	\$70.00-150.00
Spinal adjustment only	\$50.00
Therapies	\$10.00-15.00

Family Plan

1 st adult.....adj. only	\$50.00
2 nd adultadj. only	\$35.00
Child (under 17)...adj. only	\$30.00

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TIME OF SERVICE PLAN (TOS)

Patient Name _____

Account Number _____ Effective Date _____

I understand that my chiropractic care in this office may vary in cost, depending on what services I receive.
The policy I choose is:

THE TOS PLAN

TYPICAL BASIC SERVICES:

- A. Initial Consultation
- B. Exams and Re-exams
- C. Chiropractic adjustments
- D. Physiotherapy
- E. Exercise programs

Qualifications for the TOS Plan

1. No paperwork other than a receipt at the time of service is provided.
2. Payment in full is made each visit.
3. Never carry a balance on your account.
4. Keep your appointments and the schedule set by you doctor.

Patient Signature _____ Date _____

Staff Signature _____ Date _____